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ABSTRACT

This report describes and evaluates a program to improve the dental health of Hispanic migrant children in a Los Angles County school district. Difficulties in providing dental health care to this population included the high cost of dental care, limited access to dental services, poor nutrition, and lack of parental involvement. The 3-month program consisted of community awareness activities, dental screening of 134 migrant students, recruitment of 3 local dentists to accept state medical assistance payments, recruitment of parents to participate in dental health education, selection and development of bilingual dental hygiene education materials for elementary migrant students and their parents, and treatment arrangements for students with urgent dental care needs. Program outcomes indicate that 47 children who consistently participated in dental hygiene instruction did not develop additional cavities. Children whose parents were active in the program were consistent in dental hygiene practices and showed improved dental health. Although 15 children with urgent dental care needs received treatment, an additional 48 children still needed dental care at the end of the program. Although the program was successful in meeting most of its objectives, there is a need to increase long-term dental services, including preventive care, to low-income children. Appendices include parent permission form and dental screening form. (LP)

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ED 363 485

Meeting the Dental Hygiene Needs of Elementary Hispanic Migrant Students Through Supplemental Health Instruction and Services in a Community Setting

by

Carol Anne Ramnarine

Cluster 39

A Practicum I Report presented to the
Ed. D. Program in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

Nova University

1993

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Golden hearts are the resources that can empower and implement change.

The gifts associated with learning come in many packages, from the smiles of migrant children and their caring parents, to the hands of many professionals in their lives. Appreciation is expressed to all who have given forth to this practicum project.

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The Ramnarines, Patrick, Chad and Kelly Anne

The Grovers, Dad, Mom, Greg, Jim and Cyndy

God, hope, faith, and charity

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CHAPTER I

INTRODUCTION

Description of Work Setting and Community

The author's work setting was a portable office located at the campus of a community college. The community college was centralized in a suburban community with a population of one hundred and forty-eight thousand. The demographic break down of the population included a minority group of thirteen percent. Settled on the outskirts, in two distinct areas of the community, were two hundred and fifty-nine identified migrant students, ages three to twenty-one years. These students received supplemental instructional and health services. A combined service agreement was approved by two elementary districts, one secondary district and the community college district for the implementation of services. The county office of education has been given the responsibility to monitor the program.

The districts involved have a small population of former migrants and even fewer current migrants, as certified by federal guidelines. There were limited resources within the district's base program to reach the

diverse and urgent exigencies of migrant children. The district's personnel, such as Federal Project Directors, or Extended Opportunity Program Service Coordinator, were involved at the local level. The people involved in the service area were positive supporters of migrant education. They have had several years of professional experience working with federally funded programs.

The county office of education has overseen migrant services for the last thirteen years. It provides districts with support personnel whose expertise in federal projects helped to carry out the migrant program. The distance between the county office of education and the service area being defined was sixty-three miles. Its organizational structure was among the largest in the United States.

Writer's Work Setting and Role

The role of the author has been a program specialist. This position was a quasi administrative position with the county office of education. The program specialist for migrant education was responsible to aid districts in implementing their combined service agreement. The primary focus was supplementary instructional and health services for individual migrant children. The supplementary instruction includes an elementary Saturday school program, and a secondary Thursday after-school program, at the community college. In addition, individual intervention and small group counseling services were conducted at the middle school and junior high school levels. Subsidiary health services were provided which included visual screening, dental screening and physical

examinations. Priority services were given to current migrant children with the most need. The program specialist assured that services were within acceptable standards for the coordinated compliance reviews (CCR) conducted at three years intervals.

The program specialist had an assistant, whose main function was identification and recruitment of new migrant families. This position was essential to the legal record keeping. The program assistant was responsible for annual signatures of families. This was usually accomplished by home visits to update information.

Another key employee was the program secretary who has helped to maintain records and enhance communications between the families and school personnel. This position was a supporting role to both the specialist and the program assistant. The program secretary managed the office, handled incoming calls, and correspondence.

Part-time bilingual and culturally sensitive teachers were hired to teach the migrant children. There were five elementary teachers and four secondary teachers in the program design; with six bilingual instructional assistants. The college migrant students were hired to tutor younger students. There was a side benefit of using college migrant students. They served as positive role models and were able to identify with the migrant child's wants.

The three employees worked out of the portable office located at the community college campus. The program specialist was the satellite site

supervisor. The regional project director, the health service coordinator, and the program coordinator were housed in the main county facilities sixty-three miles away from the service area. The regional personnel were responsible for the twenty-eight districts' program.

There were five elementary teachers, four secondary teachers and six bilingual instructional assistants involved with the program.

The program specialist was a certificated position. The academic background of the program specialist included a bachelor's degree in art education from Inter-American University in Puerto Rico, a master degree in audio visual media from Western Michigan University, and a multi-subject certification program from Master College in California. In addition, the program specialist has completed an administration credential in education at California Lutheran University. The professional training of the program specialist included college, bilingual education strategies, and pertinent county office of education inservice workshops on migrant education.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

The situation that needed improvement was the dental hygiene practices and the condition of the teeth of migrant students who lived in the service area.

The migrant children have a significantly high amount of severe and urgent dental care needs. It was common to find multiple cavities, severely sore gums and impacted teeth. Migrant children and their families have limited access to low or reduced cost dental services. There were few dental resources for them within a five mile radius of their homes.

Inadequate nutrition and poor dental hygiene contributed greatly to the poor condition of their teeth. Unfortunately, the closest dental services were located in another valley that required personal transportation. A safe functioning vehicle with a licensed driver was not attainable to transport children to the dental office.

Furthermore, few children were registered for state medical insurance. This was due to the lack of parent information or ignorance that such services existed. There was the fear that signing up for them would result in declining amnesty. Therefore, children and adult migrants frequently went without dental care in the service area.

The regional migrant program provided supplementary dental care during an annual mobile dental clinic conducted by a prominent dental school within the state. The dental clinic was located about seventy miles away from the service area. Students who participated in the clinic missed from five to six days of school while they received dental care due to the distance, and the clinic schedule.

Certain treatments were necessary on specific days during the dental clinic due to the availability of staff. In addition, a child having multiple dental problems required several trips to the dental clinic to complete remediation. The child's mouth was repaired in quadrants, which necessitated four separate treatment days. All effort were made to limit the amount of days a child was required to travel to the clinic and miss regular school activities. The dental clinic was conducted during normal school hours. High absenteeism was already a concern for the migrant child because of the interruption in the school pattern caused by following seasonal agricultural work. Usually a school bus was hired to transport the students to the dental clinic. The time consumed in traveling to the clinic added to the long day for the migrant child. A typical day was from 6:00 AM to as late as 10:00 PM.

Last year seventeen students from our area went to the clinic. There were few slots assigned per district per school year. There was a limitation on funds available to increase the amount of slots given per district. Children with severe dental conditions had to wait for the following year if they did not make the priority list among thousands of other migrant children. If the child's guardians had no other resource for dental care then the child suffered. According to the state requirements, current migrant children received priority services. If children developed a dental problem outside the scheduled dental clinic, they were referred to dental providers. Since there were no local providers in this service area the children did not receive services until the following year. Delayed dental intervention by professionals resulted in worsened conditions and absence from school.

The problem was that the migrant students, ages three to twenty-one years, who lived in the service area, had urgent dental care needs and could not access services readily.

Problem Documentation

Reviewing the dental screening reports from the 1991-1992 school year documented the serious state of the local situation Parents asked for help to secure dental care for their children, usually when the child complained of pain. This was verified by telephone log records. The students and program needs' assessment (SAPNA) showed that ninety-three percent of the two hundred and fifty-nine identified migrant

students were screened. Only fourteen students received services at the dental clinic, although forty-nine percent of the elementary children were in need of dental care. Further testimony from the regional health service coordinator emphasized the high aggregate of urgent dental care children in our service area.

According to school personnel and dental practitioners, the most often stated reasons for limited dental care, given by the migrant parents were cost and location of services. The infrequent visits to dental clinics, high cost of dental care, and poor hygiene habits have resulted in pain and suffering and increased absences. The school attendance records and the migrant education SAPNA report showed excessive absences among the migrant students in the service area. Three percent of these absences were due to tooth pain or sore gums. Approximately fifteen students per month complained to school nurses of tooth pain.

There was a correlation between the variable age of the child, the more current the migratory lifestyle and the degree of dental needs. The older siblings had fewer dental caries in comparison to their younger brothers and sister. This is probably due to the changes in diet from corn meal, rice, beans, and poultry to processed fast foods that have higher sugar content.

Several sources documented the necessity and significance of dental services provided by the local migrant education program (Heath, 1992). The County Office of Education Regional Newsletter included in the appendix C, featured one student from the service area and described

the dental clinic. The dental clinics' student reports verified the type of services received and the nature of care required. The bus schedule showed the exceptionally long hours and amount of days children missed school to attend the clinic.

Causative Analysis

The poor dental hygiene practiced among migrant children had several compounding issues related to the cause. The local community had limited understanding of the wants of the migrant families. The lack of financial resources by agencies and migrant families made improved dental hygiene conditions unlikely.

There was an unwillingness among local dentists to take state medical insurance patients. The slow reimbursement process and the low-rate of payment to dentists made state medical insurance an unattractive option for private practice. The most humane dentists had to consider the over head expense of equipment, supplies, staff, facilities and the high cost of liability insurance, which made it difficult for them to include state medical insurance patients in their practices. Further compounding problem was the few local dental professionals who could converse in Spanish.

The migrant parents and the community at large did not recognize there was a problem or potential solutions. As a result, the community had not made a commitment to change the limited dental services for lower economic residents, regardless of whether they were migratory.

The awareness that such a problem existed became apparent before potential solutions were checked against local resources. The inadequate means of migrant parents to transport their children to other communities that did not have reduced dental services were a part of the local problem.

Dental health education was introduced in the primary grades of the local public school as small units of instruction. The public primarily relied on the parents' ability to teach their children about dental care. Among migrant parents and their children, dental health education barely existed. The emphasis was brushing teeth and did not include gum care, prevention, or dietary behaviors. The mere use of appropriate dental tools like tooth brushes, tooth paste, and dental floss were limited among migrant families. Sharing tooth brushes or limited supplies, did lead to inconsistent brushing and dental flossing habits.

The lack of bi-lingual dental health materials that were easily accessible to parents and migrant children was part of the problem. Television commercials were likely to influence the parents and their children more than sound dental information provided by trained professionals. The television commercial promoted the use of the sponsor's products and did not introduce correct information or shape appropriate behavior.

The dietary practices of migrant families had changed from the native foods of corn tortillas, rice, chicken and beans to include junk foods that were high in sugar. Another changed behavior has evolved from the

influence of the dominant culture; mothers were using bottles more and breast feeding less. The habit of allowing babies and toddlers to go to sleep with bottles in their mouths has resulted in serious injury to forming teeth. This problem was commonly called bottle mouth syndrome.

When intervention services were made available, the potential of a dependency pattern between the migrant parent and the program were likely. The parents may feel the program staff were responsible for the care of their children, and negate their own obligation to the child's dental health care.

In addition, the care giving agency had some difficulty dealing with the scheduling or cancellation of appointments. There was a cultural difference on the use of time between the Hispanic culture and the new dominant cultures in America. A scheduled dental appointment may be less important than the immediate activity or series of events occurring in the family. The most immediate requirement may change the significance of a scheduled appointment. On several occasion parents have brought their children two to three hours late to a dental appointment. The dental office was not notified, resulting in some office staff feeling confused and frustrated. The available resources were limited enough without the cultural difference separating the clients and dental professionals. Both the professional and client lacked the understanding of each other's culture and values.

Relationship of the Problem to the Literature

The preliminary literature review of the dental hygiene practices and dental care for migrant students was obtained through the ERIC system. The information acquired was somewhat limited. The ERIC system has been trying to obtain information subject specific to the migratory families as part of a rural education resource. The available information most related to this paper has been cited.

The children of Mexican American migrant farm workers have an interrupted life style of following crops; the frequent moving leads to inadequate dental care (Di Angelis, 1981). His survey of migrant children's dental needs revealed severe problems. The planning of dental treatment was difficult due to the infrequent availability of the children. The dental behavior and dental health of children whose parents attended dental sessions showed significantly greater improvement (Lee, 1978). His study of dental health programs serving migrant children emphasized the importance of parents becoming participants in the dental care process.

According to the Colorado State Department of Education (1985), multi-disciplinary teams made up of physicians, dentists, pharmacists, nurses, health care providers, nutritionists, and seasonal staff were deployed in all summer programs. The multi-disciplinary team approach was highly successful. Each team member participated in classroom

education, discussion groups, staff in-services and family night activities. Plans by the state were to continue team strategies that would better serve the migrant child.

Major barriers to good health for migrants were looked at by the Illinois project HAPPIER (Health Awareness Patterns Preventing Illness and Encouraging Responsibility) survey (Haenn, 1984). Among the necessities were dental health materials that were simple and in the native language of the parents. The high cost of health services, combined with the migrant life style and environment, were key problems facing the development of health education programs for migrants.

The supporting documentation or evidence the literature provided was the Student and Program Needs Assessment (Heath, 1992), which correlated the number of migrant students who were screened for dental problems. This includes the number of students who had received dental health services. There were students requiring dental services other than those who were recipient of services.

The literature revealed one cause for the problem to be the lack of good nutrition among migrant families. Nutrition was considered a key factor in dental health according to dental practitioners (Di Angelis, 1981). Health resources and services administration conducted a survey of support staff and found a need to instruct patients about how they could change their dietary habits.

McCormick (1989) found that to promote good personal hygiene practices among students, school health personnel should be informed about dental pits and fissures. The preventive treatment of sealing dental pits and fissures decreased the chances of caries. Informing children and their parents about this procedure could have a positive influence on decreasing the children's dental problems. School health personnel were likely to be among the first to know that a child was having a dental problem. Classroom teachers were likely to send a child with mouth pain to the school office, the nurse or health clerk. This provides the school nurse with the opportunity to advise and refer a family to dental services.

The behavior of people who sought dental care varied due to socio economic situations according to Lee (1978). The social economic status of a family had a direct relationship to the seeking of dental care. The lower economic groups were more likely to have a tooth extracted then repaired, and would visit the dentist much less frequently. The middle to higher economic groups would visit a dentist from once to twice a year. They were likely to have had professional cleanings, and would have saved a tooth when possible before extracting it. Preventive dental care was more apparent in the middle to upper middle groups.

The problem was that migrant education students ages three to twenty-one years, who lived in the service area, needed urgent dental care and could not access services readily. This problem was not unusual or unique to this geographic area. The lower economic

community groups have not received dental care as frequently as other community members.

The reviewed literature suggested a treatment plan for the lower economic group. A key component of the plan is the inclusion of parents in the dental services for their children. A multi-disciplinary team approach was an effective method for implementing a dental health education program, The team's program plan should have dealt with changing dietary habits of the migrant child. Nutrition was considered a key factor for the problem. An essential part of improving students' dental health was the knowledge base of school health personnel. Their knowledge should include information about dental pits and fissures and the practice of sealing them to prevent tooth decay..

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals

The eight goals written for this practicum were based on fifty migrant children who have participated in the dental hygiene program for a three month duration with at least one parent or guardian. The goals were as followed:

Forty of the fifty migrant children who have participated in the dental hygiene practicum project would have improved the condition of their gums, and reduced tissue bleeding documented by dentist after having brushed their teeth a minimum of twice a day.

Forty of the fifty migrant children who have participated in the dental hygiene practicum project would have reduced their number of dental cavities by remediation of existing cavities.

Three out of the one hundred and thirty dentist in the local community would have expanded their dental services to include state medical insurance patients.

The amount of migrant children in the local community with urgent dental needs would decrease from forty nine percent to the region's norm of twelve percent or less.

Twenty of the thirty-five migrant parents, who participate in training, would have increased their knowledge of good nutrition and preventive dental hygiene practices by eighty percent on a teacher made pre and post test.

Twenty-five of the fifty migrant parents or guardians, who have participated in training, would increase their knowledge of when to seek dental care and where to get professional services by eighty percent on a teacher made post test.

The three school districts serving migrant children would provide in-service activities for their health clerks and school nurses to improve their ability to identify dental pits and fissures in a child's mouth.

The two school districts serving primary migrant children would include dental hygiene in their health curriculum in first through third grades.

Expected Outcomes

The expected outcome for this practicum project was improved dental care for migrant children in the local community. It was expected that forty of the fifty participating migrant children would reduce the number of dental cavities in their teeth by half and would have improved the condition of their gums during the three month period with positive parental and community support. School health personnel training and parent education have been scheduled throughout the practicum.

Measurement of Outcomes

The results were improved dental hygiene and dental care among migrant students. This was tested by the regional dental screening assessment conducted annually. Acceptable evidence that this standard has been achieved was a decrease in the entire urgent dental care reported in the service area.

An additional result was access to dental services for state medical insurance recipients. Community rosters of low cost dental services and questionnaires were used as the evaluation tool. The increase of local dental services to three out of one hundred and thirty dental offices was acceptable standards of achievement for the three month period.

Each goal had an evaluation procedure that determined if the goal was accomplished. These procedures were listed as follows:

The condition of the migrant child's gums, and the reduction of dental cavities were rated by comparing pre and post dental screening results. The dental screenings was conducted by the same dental professional to have consistency in the evaluation process.

The one hundred and thirty dentists in the community were surveyed. The survey evaluated the number of state medical insurance patients in their practice. In order to maintain confidentiality of patient identity, no specific names were used only a numerical representation.

A numerical tabulation of the urgent dental needs of migrant children was calculated before the implementation of the practicum and compared to the results after implementation, which determined if any reduction occurred. The records of the previous years dental screening of each participant were used for the pre-implementation information. The following years dental screen would occur after implementation and would provide the data for evaluating the benefit of the practicum effectiveness.

The migrant parents knowledge of good nutrition and preventive dental hygiene practices were measured with a pre and post test written in the primary language of the parents. These instruments were designed specifically for this practicum. Similarly the parents' knowledge of where to get professional services was measured.

The signature sheets from district training and training itineraries were used to verify the school nurses and health clerks participation in dental

training. Each person trained was asked to identify a dental pit and a fissure in a child's mouth.

Evidence of the two school districts including dental hygiene in their health curriculum for primary grades were the curriculum guide and classroom teachers' plan books.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluations of Solutions

The migrant child's environment had a limiting effect upon the dental care the child received. Accessing community resources did lessen with the lower economic base. The conditions encountered by traveling between communities and living in substandard housing caused problems. In the local community lower economic children have had less options available to them compared to other groups of children. There needed to be an increased public awareness to recognize the issues facing migrant children and dental health. Children were dependent upon an adult society that had ignored the dental needs of children. The author sought out workable solutions for a short term that have had the potential of evolving into long term answers.

In gaining answers for the dental care issues of the migrant child, several possibilities were considered. This complex requirement requisitioned the cooperative effort among professionals, community members and the migrant families. The subject, the migrant child, was a willing participant, who recouped a happy smile when dental pain ceased and carious teeth were repaired.

The possible solutions extracted from the literature included three themes. They were as follows:

- The development of a regional multi-disciplinary health services team to teach health education to migrant students. The team focus was improved dental hygiene behaviors of migrant students (Colorado State Department of Education, 1985).

- The involvement of parents in the dental screening and dental clinic did significantly increase dental hygiene practices of migrant children (Lee, 1978).

- The improvement of the child's diet through good nutrition and parental training has been a meaningful contribution to upgrading the health conditions of the migrant child (Di Angelis, 1981).

Description of Selected Solutions

The ideas that the author did generate to resolve the problem of poor dental hygiene practices by migrant children and their parents were:

- Identify an already tested dental hygiene program. Then implement it at the school sites with the largest migrant student populations.

- The author designed migrant parent training sessions in Spanish on beneficial dental hygiene practices. Bilingual professionals conducted the parent training. The county parent education center expressed willingness to develop videotapes covering this topic for public broadcasting. The author has had professional experience in developing instructional materials.

- During the project the author developed a migrant student's daily progress chart for flossing and brushing. This chart included annual appointments for cleaning and scheduled appointments for dental repairs.

- On a long term plan the author organized a city wide incentive program. The program was for local dentists, the regular classroom teachers, and parents. The incentive program was designed to help migrant students improve their dental hygiene knowledge and practices.

Some ideas that the author generated to augment local low cost dental services for migrant families included the following:

- Public knowledge that the problem exists was increased through public hearings, news coverage, and information leaflets. The author worked with community groups to establish a dental aid fund for children with financial deprivation and who meet criteria identified by the community groups. The community groups included dental practitioners and experienced fund-raisers.

- A list of concerned dentists practicing in the area was established to help the regional health service coordinator contract migrant education dental services. The author requested the city to develop bus commuter services to the closest dental clinic that accepted state medical insurance patients.

- The author considered organizing a mobile dental clinic in the local community with the nearest dental school. The funds to hold such a clinic are being raised by a local nonprofit organization interested in serving school age children.

- The local political framework was in place to support increased services to the lower economic residence. Several town meetings have been held by the city council to provide public input to meet the diverse requirements of the community through block funding. Community resources, with special project funds from the regional migrant education program have allowed the service area to carry out

an improved dental health program. The author has had a good track record with the local community and the county for effectively implementing change for the betterment of migrant families.

Report of Action Taken

The improvements of migrant education dental health were based on a time line of three months. Several actions were taken during each month. The following were included:

The first month

- Dental screenings were set up for all migrant students.
- Local dentists and hygienists were recruited to participate in the project.
- Parent permission slips for dental services for their children were obtained.
- Parents were recruited to participate in the project.
- Local screening sites were set up that had adequate facilities for quickly checking children's teeth. Most of the sites selected were on the regular school campuses.

- Transportation for students and parents to attend the dental screening were set up with the regular school bus schedule. Parents were otherwise responsible for transporting their children.

- The dental screening for eligible migrant students were conducted.

- All dental screening evaluation forms were reviewed with professional input by a pediatric dentist and the county office of education's health staff.

- Areas in the community lacking dental health services for lower economic children were identified.

The second month

- Bilingual dental hygiene education materials were selected.

- Dental behavior charts were developed.

- Schools with large migrant student populations were selected to participate in the dental hygiene program.

- Classrooms with migrant students with dental hygiene needs were selected from school sites in the service area.

- Grade level dental health curriculum were introduced at Saturday Migrant School with the help of professional volunteers.

- Newspaper coverage of dental project was released to the local papers.

- Students' home progress was monitored on charts that were brought to Saturday School. Incentives were given to the participants.

- A parent dental hygiene education component was developed. The instruction was integrated with Parent Advisory Council meetings (PAC).

- The implementation of a school dental hygiene program continued.

- Nutrition units in the school curriculum that related to dental health were taught.

- Students were scheduled for services with mobile dental clinic or any local resources.

The third month

- Students were selected to participate in clinic according to screening results.

- Student visits to local dentist offices were organized.

- Study trips were organized to the health museum's tooth exhibit.

- Dental students, dental assistants, and dental hygienists were recruited to participate in the project.

- Practicum project goals were reviewed and the project progress was assessed.

- Additional ideas and resources were generated to help meet the students' dental needs.

- Plans were developed for continued dental hygiene services after the practicum period.

- A community dental hygiene task force was established.

- As additional data was obtained, improvements to the project design were implemented throughout this practicum.

- The community's awareness of the project effectiveness and the continued dental services needs for migrant children was increased.

- Low income health needs for the community based on project plans and additional resources were prioritized.

- Information about dental resources were distributed to local schools, public health agencies, and migrant families.

CHAPTER V

RESULTS

Discussion and Recommendations

The goal of the practicum was to improve the dental care of migrant students by providing dental services in the local community and through dental hygiene instruction at a supplemental Saturday school with parent involvement. The anticipated outcome of this practicum project was to improve the dental care for migrant children in the local community. This main goal was met by the standards expected for a three month study. More students participated in the project then originally planned. The author did not feel it was appropriate to eliminate interested students due to the nature of the project. There were one hundred and thirty-four children served.

The forty-seven students who consistently participated in the dental hygiene instruction did not develop additional cavities. There was an

average of eighty-eight students attending the Migrant Education School program each Saturday.

To provide dental services to the migrant children, dentists that accepted state medical insurance were identified. Three out of the one hundred and thirty dentists in the area did expand their services to include state medical insurance. This met the objective. However, there was no available dentist that was bilingual or knowledgeable of the migrants' culture. This remained to be a community problem and requires additional consideration.

The school nurses and health clerks were not trainned to identify pits and fissures in a child's mouth. This objective was not met. The practicum scheduled conflicted with the local school nurses need to complete other school related tasks such as vision, and hearing screenings. This activity was canceled and should be rescheduled at a less busy time in the school year.

The three school districts serving migrant children recognized the need for dental hygiene curriculum. The objective to include this curriculum into the regular school health component has not yet been met. This should be an item for the curriculum committee to review and consider at the next textbook adoption. This would take another school year to implement.

During the first four weeks of the practicum, the same staff from a local pediatric dental office conducted the dental screenings on the one hundred and thirty-four migrant participants. The screenings were held

during the regular school day at six elementary school sites in the health facilities. Every effort was made to return to the school sites to screen any absent students. Three students did not receive services. The pre-school age migrant students were screened during a supplemental Saturday school program. Written parent permission was given for each student screened. Thirty-five parents consistently participated during the entire project and one pre-dental student was an active volunteer. The dental screening resulted in forty migrant students needing urgent care, twenty-three ranked moderately urgent and seventy-one were non-urgent dental needs.

Low cost dental services were found for patients with state medical insurance at two dental offices that were not in proximity to the migrant families' homes. The average distance was twenty miles from the children's homes. However, the services were very restrictive and did not provide immediate relief to those children with moderately urgent or urgent dental needs. Two students with non-urgent dental needs who were eligible did receive services.

During weeks five through eight of the project, bilingual dental hygiene materials were selected and used at the supplemental Saturday Migrant program. The material chosen was a colorful illustrated student book named Los Dientes Concept Health en Español (1992). The Spanish and English version of this book were used throughout the practicum. In addition the pre-dental student developed original curriculum to supplement the commercial materials selected. He assisted in the creation of dental behavior charts that included a tooth brushing calendar and rubber stamps. The rubber stamp images were insects representing bacteria in the mouth

and a smiling tooth that rewards students for their positive progress. The students eagerly responded to the incentive charts. An average of fifty students were instructed on dental hygiene and used the charts. Approximately thirty-five out of the fifty students consistently worked with the incentive charts and seem to benefit from the instructional program. This is five students less then desired. There appeared to be a positive correlation among the thirty-five students and their parents' participation in the project. Those students whose parents participated at least two out of the three parent trainings were more consistent in brushing their teeth. The condition of the students gums improved but continuos dental hygiene would be needed for further improvement.

The study trip to the health museum's tooth exhibit was postponed for the migrant summer school program. This unfortunate change was due to budget restrictions imposed by the county office of education. The county office of education has been experiencing a deficit and has restricted study trips.

During the last four weeks of the practicum project fifteen students were selected and scheduled to receive repair services at a dental clinic paid for by the county migrant education funds. The fifteen students were selected based on federal regulations requiring priority of service be given to those students with the most serious needs and with a more frequent mobility pattern. The forty students with urgent dental needs were reviewed by the pediatric dental staff. The records of the current mobility status of those students were reviewed by the migrant education program assistant. Then, fifteen students were identified as eligible for the clinic.

The number of students who could be served was the decision of the county migrant education health coordinator. The allocation was primarily based on a per district funding formula and availability of funds. The cost of the dental repairs has been negotiated at one hundred and fifty dollars per student. The dental clinic was organized at a local dental office and scheduled for one Friday. The atmosphere of the clinic was pleasant and appealed to the young children. The parent of each child was present at the clinic.

As result of this practicum, it has become apparent that much more needs to be done to increase services to low-income children in need of dental care. There are still twenty-five urgent care migrant children not being served, plus the remaining twenty-three moderately urgent. The seventy-one non-urgent students still have the need to participate in preventive dental services like cleanings and regular check up.

Discussion

The migrant families continue to face the challenge of obtaining adequate and affordable dental care for their children. The local level of consciousness has been raised to encourage both the health professionals, school districts and the community to continue to find solutions to this conflict. The community task force has been given a copy of this practicum report and asked to find additional resources to continue dental care services to migrant children and other low income groups.

It is not surprising that those children whose parents were active participants were more consistent with the dental hygiene instructional program. Parent participation was often considered a key factor in student success.

The bilingual materials selected only began to touch on the surface of potential topic to cover on dental hygiene. There may be a need to develop additional curriculum in media formats. What did occur was the teachers began to take a more constructive interest in the program. The teachers were delighted to have dental health incorporated into the Saturday school program. The regular classroom teachers were informed of the dental care needs of their students and the results of the services .

The budget restrictions of local school districts, the regional office and the state department of education accounts for the few number of students who received dental repair services. There is still much need to reform our education systems to reflect more of the students' needs including health services, and rethink our national financial resources.

Recommendations

The author would recommend that other communities look at their need for low income dental services; trying to identify how accessible the services are and if they are used. It would be very likely that other target populations of children would benefit from dental services, intervention strategies and dental hygiene instruction.

The duration of three months was somewhat limiting although much was accomplished in that period. The author would recommend expanding the time to a full school year or twelve month period.
Another conflict that was difficult to control was the frequency of the migrants students attending the supplemental Saturday School program. It would be appropriate to develop behavioral reward incentives to encourage consistent participation.

The use of a pediatric dental office was ideal because of the youthful environment and arrangement of dental chairs. The eight chairs used were in an open atmosphere, that allowed one child to observe another. The peers encourage each other and aided in reducing resistance to dental care by frightened children. By using the same dental professionals for the screening and for the treatment of the children, it helped the students to be more familiar with the staff before the actual dental clinic.

The involvement of the parents was essential and should be encouraged. Parents were able to understand the significance of their own dental hygiene behavior. The parents acted as positive role models. In some incidents the parents own fears were lessen by braver children.

Dissemination

During the 1993 National Migrant Education Conference the author has been scheduled to disseminate the results of this practicum in a session. It is anticipated that the information learned from this practicum will be shared with more than fifty professional colleagues at the conference.

Then, those conference participants will share relevant data with others at their regional and local staff meetings.

The ERIC system's Clearinghouse for Rural Education and Small Schools (CRESS) has already contacted the author asking for copies of this practicum and any other papers written that pertain to Migrant Education. After the completion and acceptance of this practicum, a copy and appropriate forms will be sent to them.

The local school districts and community interest groups will receive copies of the results in the form of a newsletter or flyer. The 1993-1994 Service Agreement will reflect health service changes based on the more effective method of serving the dental needs of the migrant child. In addition, the local newspaper is planning to continue the coverage on the migrant families and their health needs per the city editors request for on going information.

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APPENDIX A

PARENT PERMISSION SLIP

Los Angeles County
Office of Education

MIGRANT EDUCATION

Autorizo a los Dres. Baumgartner, Singer y cualquier otro doctor voluntario para que hagan un examen dental a mi hijo/a y los absuelvo de toda responsabilidad.

I give my permission to Dr. Baumgartner, Dr. Singer, and any volunteer doctor to screen my child and I release them from all responsibility.

_____ _____

Firma del padre/Parent's signature Fecha/Date

Nombre/Children's names	Escuela/School	Maestra/Teacher	Grado

APPENDIX B

DENTAL SCREENING FORM

Los Angeles County Office of Education

MIGRANT EDUCATION REGION X

NAME OF STUDENT	DATE
NAME OF SCHOOL	MIGRANT ID NUMBER
NAME OF DISTRICT	MIGRANT STATUS

Dear Parent:

Today your child participated in a dental screening. A dentist/nurse checked your child's teeth. Please note that the examination was done without x-rays and was done only visually. The following conditions were noted:

☐ 1. Very Urgent — functional and social disability conditions requiring rapid attention
- ☐ a. pain and acute infections (including periodontal disease)
- ☐ b. suspected neoplasms (tumors)
- ☐ c. dental caries into or near the pulp
- ☐ d. teeth obviously requiring extraction
- ☐ e. disfiguring conditions, such as missing or badly decayed interior teeth

☐ 2. Moderately Urgent — Conditions requiring care within six months.
- ☐ a. extensive penetration of caries into dentin
- ☐ b. space maintenance for children
- ☐ c. numerous cavities – none with extensive penetration

☐ 3. Non-Urgent — conditions requiring care that is postponable for a period of time
- ☐ a. caries in deciduous teeth which will exfoliate soon
- ☐ b. incipient caries
- ☐ c. better brushing
- ☐ d. call your dentist for dental checkup

☐ 4. Orthodontic consultation may be needed. Ask your dentist about this at next routine checkup.

☐ 5. Your child's mouth appears to be in good condition.

This screening is **NOT** intended to replace the normal dental checkup. Children should visit their dentist at least once a year.

GOOD DENTAL HEALTH AND GOOD DENTAL HABITS ARE LEARNED AND DEVELOPED WHEN YOUNG.

Sincerely,

Ruth Heath, RN, MS
Coordinator, Health
Migrant Education — Region X

Form No. 604-215 (5/88)